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No. 95-266

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

CARRIE JAFFEE, as Special Administrator for RICKY ALLEN, SR.,

Petitioner,

v.

MARY LU REDMOND and VILLAGE OF HOFFMAN ESTATES, ILLINOIS,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF AMICUS CURIAE OF THE AMERICAN ASSOCIATION OF STATE SOCIAL WORK BOARDS IN SUPPORT OF RESPONDENTS

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BRIEF AMICUS CURIAE OF THE AMERICAN ASSOCIATION OF STATE SOCIAL WORK BOARDS IN SUPPORT OF RESPONDENTS

I. INTRODUCTION

A. American Association of State Social Work Boards

The American Association of State Social Work Boards ("AASSWB") is a Virginia not-for-profit organization established in 1979 whose membership consists of the state boards of social work from 52 jurisdictions (50 states plus Washington D.C. and Virgin Islands).[1] AASSWB conducts the following activities with and for the benefit of these Boards in aiding such governmental agencies in the protection of public health:

> AASSWB prepares examinations at four levels (basic, intermediate, advanced, clinical) used by the various Boards to determine minimum competence as one criteria for eligibility for licensure of social workers. The examinations are used by all states, the District of Columbia and the Virgin Islands, except Michigan which does not exam candidates as part of its credentialing process.
>
> AASSWB acts as a clearinghouse for Boards in regard to gathering and disseminating final disciplinary actions against licentiates for purposes of utilization by Boards in determining eligibility for licensure by reciprocity and/or endorsement.
>
> AASSWB conducts educational seminars for Boards and their representatives from the attorneys general offices in areas that assist them to become better and more efficient state officials in carrying out their statutorily mandated duties to protect the public health.
>
> AASSWB publishes newsletters, surveys of law and other relevant social work publications to aid Boards in

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[1] For purposes of this Brief Amicus Curiae, "Boards" shall refer to the state legislatively created governmental agency empowered to license, credential and regulate the practice of social work.

understanding the process of state licensure and regulation of social workers.

Through its programs, AASSWB has lessened the burdens legislatively placed upon Boards by providing services not otherwise available nor economically feasible. AASSWB has no individual social workers as members, only Boards of social work.

All jurisdictions including the District of Columbia and Virgin Islands, license or credential social workers as a prerequisite to practice in the profession. State legislatures have created Boards to regulate the profession and, in turn, protect the public health. Generally, Boards exist either as an independent body or alternatively in an advisory capacity to an umbrella or composite department. Independent, or autonomous Boards, are generally given the power to adopt regulations designed to comply with such statutory powers to regulate the profession through the licensure, renewal of licensure and disciplinary process. Departments generally govern numerous, if not all, licensed professions within that particular state and receive recommendations from the advisory board relative to regulatory issues. A few states have a hybrid board regulating allied mental health professionals, including, for example, social workers, marriage and family therapists, substance abuse counselors, psychologists or others. Most states have supervision and/or experience requirements mandated prior to licensure to independently practice, and continuing education as a prerequisite to maintaining or renewing licensure status.

AASSWB has developed and maintains an examination program. This program consists of examinations used by Boards to determine minimum competence as one criteria in the licensure eligibility process. The examination programs are developed and maintained under principles to

support their defensibility and the reliability of scores generated therefrom. The development process follows psychometric principles and guidelines set forth by the American Psychological Association and Equal Employment Opportunity Commission, as well as others. AASSWB offers its Boards examinations at four levels (basic, intermediate, advanced, and clinical). With the exception of Michigan, all jurisdictions (including the Virgin Islands) use at least one level of the examination in the licensure or credentialing process. Numerous states use multiple examinations to license social workers at varying levels. These levels include licensed clinical social worker, licensed master social worker, licensed baccalaureate social worker and synonymous derivatives thereof. Generally, the licensed clinical social worker (sometimes referred to as an independent clinical social worker or other similar titles) has attained the highest level of education (masters or doctorate degree), supervision experience, undertaken extensive supervised experience in the profession, and has substantiated such knowledge and experience through the successful completion of the AASSWB clinical or advanced examination prior to receipt of a state license enabling the individual to engage in the independent practice of social work.

As an organization which maintains as its sole purpose the protection of the public health through the assistance to Boards, AASSWB has witnessed the recognition by state legislatures of the societal interests and benefits of licensing or credentialing social workers. This recognition has come in numerous forms including federal laws, licensure and certification statutes and the creation of Boards to oversee the licensure, renewal of licensure, continuing education, continued competency, and discipline of social workers.

B. Consent of Parties

This brief *Amicus Curiae* in support of respondents is filed with the consent of all parties.

C. Summary of Argument

AASSWB has elected to file its brief *Amicus Curiae* in this action to provide the United States Supreme Court with a national public health perspective. At stake in the issues presented to this Honorable Court is a fundamental necessity of psychotherapy, the right of the patient to counsel with a licensed clinical social worker in confidence under protections afforded by a judicially recognized privilege. The Supreme Court is presented with the opportunity to recognize the social work profession as an essential player in providing meaningful mental health care services. Such a position would be for the benefit of society, comport with state licensing and privilege laws and be commensurate with the educational and professional status achieved by social workers.

Since the time of adoption of Rule 501, social work has emerged as a leader in the role of psychotherapy. Federal legislation, state licensing laws and other related legislation (including privilege statutes), the licensure process including educational levels attained, supervision, continuing education, discipline and societal needs compel recognition of social workers as entitled to privilege protection. As providers of such mental health care services, a licensed clinical social worker-patient relationship is based upon a foundation of trust and confidence. Any concession to such confidentiality would undermine the therapeutic purpose of the relationship. Thus, as an essential participant in the provision of mental health care services, and to protect the integrity of the therapeutic process, AASSWB respectfully requests that this Honorable Court affirm the holding of the

Seventh Circuit Court of Appeals in this matter and recognize the licensed clinical social worker as entitled to a privilege under the Federal Rules of Evidence, Rule 501.

II. TERMINOLOGY

Before embarking upon the merits of the AASSWB arguments, it is essential to address terminology to be used interchangeably throughout this brief. The profession of social work covers a broad range of specialties and functions in a wide variety of settings. As social work continues to expand, its vocabulary and related definitions becomes more complex. There is considerable overlap in practice and settings both within the profession of social work and other allied mental health professions. It should be noted that clinical social workers frequently identify themselves as "psychotherapists" or "clinicians."[2] Indeed, clinical social workers and psychologists practice in closely aligned or allied fields and possess knowledge of fundamental psychological principles. As has been stated:

> We note that the field of practice engaged in by defendant here more closely resembles the practice of psychology rather than social work, as those two practices are currently defined in the Illinois revised statutes [Citations omitted]. Because of the apparent overlap in these two fields, we think the proofs may well reveal that defendant possessed or should have possessed a basic knowledge of fundamental psychological principles.

Horak v. Biris, 130 Ill. App. 3d 140, 85 Ill. Dec. 599, 474 N.E. 2d 13, 18 (Ill. App. 2 Dist. 1985). Social workers are statutorily authorized to apply knowledge and skills to "treatment procedures" defined as "individual, marital, fam-

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[2] Gibelman, Margaret, *What Social Workers Do*, at XVI (National Association of Social Workers Press (1995).

ily and group psychotherapy."[3] Accordingly, clinical social workers[4] practice psychotherapy and provide other mental health care services.

III. THE EVOLUTION OF THE COMMON LAW COMMANDS RECOGNITION OF THE PSYCHOTHERAPY PRIVILEGE UNDER RULE 501

A. Federal Rule of Evidence 501

Federal Rule of Evidence 501 (Rule 501) provides that the existence and scope of evidentiary privileges are to be "governed by the principles of the common law as they may be interpreted by the courts of the United States in light of reason and experience."[5] Congress did not intend that the recognition of privileges under Rule 501 be limited to those that existed under common law at the time of the adoption of the Rule. To accept such a limited application would stagnate the law and render Rule 501 illusory. The language of Rule 501 allows the expansion or recognition of privileges by providing that the courts be governed by common law principles as they "may" be interpreted rather than as they "have been" or "were" interpreted in the past.[6]

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[3] 225 ILCS 20/3(6).

[4] Except where noted, "social worker" shall refer to clinical social worker and also may be referred to as "psychotherapist." Such terms may be used interchangeably in describing the general functions under which a clinical social worker would provide service. In general, mental health care services provide a therapeutic purpose for patients.

[5] Fed. R. Evid. 501.

[6] Baytion, Catherine M., *Note & Comment, Toward Uniform Application of a Federal Psychotherapist-Patient Privilege*, 70 Wash. L. Rev. 153, 154 (1994).

In its election not to adopt proposed Rule 504,[7]

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[7] Proposed Rule of Evidence 504 provided:

PSYCHOTHERAPIST-PATIENT PRIVILEGE

(a) Definitions.

(1) A 'patient' is a person who consults or is examined or interviewed by a psychotherapist.

(2) A 'psychotherapist' is (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition including drug addition, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.

(3) A communication is 'confidential' if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family.

(b) General Rule of Privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional condition, including drug addiction, among himself, his psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist, including members of the patient's family.

(c) Who May Claim the Privilege. The privilege may be claimed by the patient, by his guardian or conservator, or by the personal representative of a deceased patient. The person who was the psychotherapist may claim the privilege but only on behalf of the patient. His authority to do so is presumed in the absence of evidence to the contrary.

(d) Exceptions.

(1) Proceedings for hospitalization. There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

(continued...)

Congress clearly demonstrated its intent under Rule 501 that privileges be determined on a case-by-case basis.[8]

Indeed, this Court stated that Rule 501 "manifested an affirmative intention not to freeze the law of privilege, [to] provide the courts with flexibility to develop rules of privilege on a case-by-case basis and to leave the door open to change." *Trammel v. United States*, 445 U.S. 40, 47, 100 S. Ct. 906, 63 L. Ed. 2d 186 (1980).

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[7] (...continued)

(2) Examination by order of judge. If the judge orders an examination of the mental or emotional condition of the patient, communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise.

(3) Condition an element of claim or defense. There is no privilege under this rule as to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense, or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense.

Proposed Rule 504, 56 F.R.D. 103, 240-41 (1973).

[8] S. Rep. No. 1277, 93d Cong., 2d Sess. 11, reprinted in 1974 U.S. Code Cong. & AD. News 7051, 7059 wherein it was stated that:

> The committee has received a considerable volume of correspondence from psychiatric organizations and psychiatrists concerning the deletion of Rule 504 of the rules submitted by the Supreme Court. It should be clearly understood that, in approving this general rule as to privileges, the action of Congress should not be understood as disapproving any recognition of psychiatrist-patient, or husband-wife, or any other of the enumerated privileges contained in the Supreme Court rules. Rather our actions should be understood as reflecting a view that the recognition of a privilege based on a confidential relationship and other privileges should be determined on a case-by-case basis.

Rule 501 allows, by its very nature, for development and expansion of the privilege. Certain Appellate Circuits have improperly focused on the term "common law" as limiting the application of Rule 501. The Fourth, Fifth, Ninth and Eleventh Circuits have refused to create or recognize the psychotherapist-patient privilege because it was not part of the common law at the time of the adoption of Rule 501. *Slaken v. T.C. Porter*, 737 F. 2d 368 (4th Cir. 1984) cert. den. 470 U.S. 1035, 105 S. Ct. 1413, 84 L. Ed. 2d 796; *United States v. Meagher*, 531 F. 2d 752 (5th Cir. 1976) cert. den. 429 U.S. 853, 97 S. Ct. 146, 50 L. Ed. 2d 128; *In re Grand Jury Proceedings*, 867 F. 2d 562 (9th Cir. 1989) cert. den. 493 U.S. 906, 110 S. Ct. 265, 107 L. Ed. 2d 214; *United States v. Corona*, 849 F. 2d 652 (11th Cir. 1988) cert den. 489 U.S. 1084, 109 S. Ct. 1542, 103 L. Ed. 2d 846.

The Tenth Circuit declined to recognize the privilege but limited its decision to the psychotherapist-patient privilege in a criminal sexual abuse context and specifically left the issue open for future recognition. *United States v. Burtrum*, 17 F. 3d 1299 (10th Cir. 1994) cert. den. 63 USLW 3262, 115 S. Ct. 176, 130 L. Ed. 2d 112.

The Second and Sixth Circuits recognize the privilege in furtherance of the Congressional record and *Trammel*. *In re Doe v. Diamond*, 964 F. 2d 1325 (2nd Cir. 1992); *In re Zuniga*, 714 F. 2d 632 (6th Cir. 1983) cert. den. 464 U.S. 983, 104 S. Ct. 426, 78 L. Ed. 2d 361.

The rule and rationale articulated by the Second and Sixth Circuits and embraced by the Seventh Circuit in the present case accurately reflects the appropriate application of Rule 501.

B. Evidentiary Principles

Evidence serves multiple functions. A primary function is to facilitate the search for truth. Yet conflicting functions

justify many exceptions to this general principle. The psychotherapist-patient privilege is one such exception. This privilege promotes two goals: one, to foster uninhibited relationships between psychotherapists and their patients, thus promoting the effective treatment of mental and emotional conditions. A second goal is to protect privacy.[9] Although disclosure of communications between a psychotherapist and patient could benefit society by assisting in the search for truth, the devastating effect on the treatment of mental and emotional conditions would far outweigh the benefits in many cases.[10] While the Supreme Court has acknowledged that the primary role of the court is to serve justice, the enforcement of basic moralities by courts should at times be deemed more important than the full utilization of all relevant evidence in a particular case. *Elkins v. United States*, 364 U.S. 206, 234-235, 80 S. Ct. 1437, 4 L. Ed. 2d 1669 (1959). Although revelations made at counseling sessions may not be relevant, recognition by the Supreme Court of a psychotherapist-patient privilege will enforce the basic moralities and privacy issues necessary for an effective relationship.

Petitioner argues that crucial evidence will be excluded upon the recognition of a privilege. Such arguments presuppose the existence of admissible "evidence." In order for matters to be evidence they must be material, relevant, and admissible.[11] Revelations made during therapy sessions do not conform to such admissibility requirements. Quite to the contrary, most information communicated to a psycho-

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[9] *Note & Comment, Toward Uniform Application of a Federal Psychotherapist-Patient Privilege*, supra note 6, at 153.

[10] Slovenko, Ralph, *Psychiatry and a Second Look at the Medical Privilege*, 6 Wayne L. Rev. 175, 193 (1960).

[11] Generally, Federal Rules of Evidence.

therapist is not factual; rather it is an abstract expression of one's inner feelings and emotions. Such impressions lack accuracy, are speculative and not necessarily sincere rendering them irrelevant and immaterial.[12]

Petitioner's characterization that hypnosis is synonymous with psychotherapy (Petitioner's Brief, p. 23) is misguided and illustrates the specious nature of her arguments. Apparently, in order to disclose the "truth," Petitioner finds it necessary to equate social work practice with a completely different field and malign social workers as therapists who offer "suggestive cues" and encourage "behavioral confirmation." Petitioner has obviously overlooked the purpose of therapy under these circumstances, that is "work[ing] out the pain and anguish undoubtedly caused by Allen's death."[13]

IV. AS A LEADER IN THE ROLE OF PSYCHOTHERAPY, SOCIAL WORK IS A PROFESSION ENTITLED TO PRIVILEGE RECOGNITION UNDER RULE 501

A. What is Social Work

Petitioner throughout the course of this litigation has attempted to relegate the social worker to a rung so low on the ladder of professionals that the courts would not recognize a privilege between such social worker and patient. To the contrary, social work practice has evolved as a leading player in the role of providing psychotherapy.[14] This recognition has not only been noted through the media but has

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[12] Slovenko, Ralph, *Psychiatry and a Second Look at the Medical Privilege*, supra note 10, at 192.

[13] *Jaffee v. Redmond*, 51 F. 3d 1346 (7th Cir. 1995).

[14] Goleman, Daniel, *Social Workers Vault into a Leading Role in Psychotherapy*, New York Times, April 30, 1985 at C1.

also been legislatively embraced at both the state and federal levels. Petitioners (and certain Appellate Circuits) apparently have a lack of understanding of the important job functions of social workers and the variety of fields under which they function.

Psychotherapeutic services are rendered by clinical social workers through independent private practice and mental health care facilities.[15] Practice areas include coverage of service on behalf of children, community organization, family services, corrections, group services, medical clinics, mental health, public assistance, school social work, aged, substance abuse, mental-developmental disabilities, other disabilities, occupational social work, as well as others.[16]

In Illinois, the practice of social work is defined as including:

> Social services to individuals, groups, or communities in any one or more of the fields of social case work, social group work, community organizations for social welfare, social work research, social welfare administration or social work education. Social case work and social group work may also include clinical social work, as long as it is not conducted in an independent practice.[17]

Clinical social work practice in Illinois is defined as providing:

> Mental health services for the evaluation, treatment and prevention of mental and emotional disorders in individuals, families and groups based on knowledge and theory of psychosocial development, behavior, psychopathology, unconscious motivation, interpersonal relationships, and environmental stress.[18]

[15] Encyclopedia of Social Work 502-512 (19th Edition 1995).

[16] Gibelman, M. & Schervish, P.H., *Who We Are: The Social Work Labor Force as Reflected in the NASW Membership*, Washington, D.C. NASW Press (1993).

[17] 225 ILCS 20/3(9).

The National Association of Social Workers model definition of the practice of social work is as follows:

> Social work practice consists of the professional application of social work values, principals, and techniques to one or more of the following ends: helping people obtain tangible services; counseling and psychotherapy with individuals, families, and groups; helping communities or groups provide or improve social and health services; and participating in legislative processes. The practice of social work requires knowledge of human development and behavior; of social, economic, and cultural institutions; and of the interaction of all these factors.[19]

As can be seen by the referenced definitions, specifically defining a diverse and complex profession can be difficult. As aptly stated by Senator Daniel Inouye (D-HI):

> The scope of social work practice is remarkably wide. Social workers practice not only in the traditional social service agency, but also: in elementary schools; in the military; in business, factories, and offices; in federal, state and local government agencies and legislative bodies; in private practice—as individuals, family and marriage therapists; in hospitals and in mental health facilities; in courts and correctional settings; in home and health care; and in services to the elderly. In fact, social workers can be found anywhere and everywhere there are people who need the help of a professional to alleviate personal or social problems.[20]

[18] 225 ILCS 20/3(5).

[19] National Association of Social Workers, pp. 4.-5 (1973).

[20] Senator Daniel Inouye, addressing Congress "Going on Record" 1986.

The role and function of social workers is affected by both the larger environmental context in which the profession functions (the economy, social need, cultural, political preferences, and so on) and the stage of development of professional thought, leadership, direction, technology, and mission and goals.[21] As society changes, so do the services provided by social workers. Society has become more complex and negative issues have become pervasive, including crime, unemployment, single parent families, lack or quality of education, drug and alcohol abuse and the like, significantly increasing the need and demand for social work services. To illustrate, studies have shown that social workers are the dominant providers of mental health services in this country. For example, in approximately 1000 counties, one third of the counties in the country, social workers are the only licensed providers of mental health services.[22] It has been estimated that as much as 65% of all psychotherapy and mental health services are provided by social workers.[23] In 1993, only 500 medical school graduates selected a residency in psychiatry, and universities awarded fewer than 3500 doctorate degrees in psychology. During that same time period, schools of social work graduated 9000 masters degreed social workers.[24] And in 1975, the number of practicing psychiatrists (26,000) and clinical social workers (25,000) were virtually identical. At such time, there were approximately 15,000 clinical psychologists and 6000 marriage and family therapists. In 1985, ten years later,

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[21] Gibelman, *What Social Workers Do*, supra note 2, at 2.

[22] Goldstein, S. R., *If Past Is Prologue, Future Is Bright*, NASW News, p. 2 (July 1994).

[23] Goldstein, S. R., *Our New Challenge: Being "Insiders"*, NASW News, p. 2 (March 1993).

[24] Goldstein, S. R., *If Past is Prologue, Future is Bright*, NASW News, p. 2 (July 1994).

there were 60,000 clinical social workers compared to 38,000 psychiatrists, 28,000 counselors and 33,000 psychologists.[25]

B. Crisis Intervention

Further recognition of social work as an important and essential participant in mental health care services is demonstrated by the participation of social workers in crisis intervention. Crisis intervention is a therapeutic process used to help clients in a crisis develop effective coping mechanisms.[26] Effective intervention can lead to an acknowledgment of the issue, recognition of its impact, and development of new behaviors for coping with similar experiences.[27] Such intervention can lead to positive growth and outlook on society.

Social workers are recognized and relied upon during crisis situations both on a smaller scale as well as national catastrophes including the 1994 U.S. Air Flight 427 accident and the 1989 United Airlines Flight 232 accident.[28] Social workers in Houston provided counseling to the families of astronauts and to NASA employees in the wake of the disaster involving the space shuttle Challenger and counseled teachers and students in Concord, New Hampshire, home of Christy McAuliffe, the school teacher who was a member of the space shuttle's crew.[29] Social workers also mobilized in the aftermath of Hurricane Hugo and Hurricane Andrew, provided mental health services in the wake of the Exxon Valdez oil spill, the 1986 U.S. Post Office

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[25] Gibelman, *What Social Workers Do*, supra note 2, at 24.

[26] Gibelman, *What Social Workers Do*, supra note 2, at 37.

[27] Gibelman, *What Social Workers Do*, supra note 2, at 37.

[28] Gibelman, *What Social Workers Do*, supra note 2, at 37.

[29] Gibelman, *What Social Workers Do*, supra note 2, at 37.

shooting spree in Oklahoma, and the terrorist bombing incident in Oklahoma City at the Alfred P. Murrah Federal Building.[30]

C. Societal Benefits

One must not lose sight of the benefits to society as a whole of the effective mental health services provided by social workers. Society recognizes and dictates the disparities between what is and what should be and the need to rectify any such conditions. Society as a whole benefits from social workers rendering their professional care. Societal reliance upon social workers continues to grow based upon an ever emerging complex, technical, specialized and fragmented society which places pressure upon the individual's ability to cope with these changes.

D. Federal Recognition

Congress has also recognized social workers as important providers of social services and psychotherapy. The Omnibus Budget Reconciliation Act of 1989[31] included provisions for clinical social workers to join the limited class of mental health professionals eligible for reimbursement under Medicare. The Family and Medical Leave Act of 1993[32] includes clinical social workers as health care providers. National social welfare policies reflected in Stewart B. McKinley Homeless Assistant Act of 1987,[33] the Adoption Assistance and Child Welfare Act of 1980,[34] the Americans With Dis-

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[30] Gibelman, *What Social Workers Do*, supra note 2, at 39-40.

[31] Pub. L. 101-239, Dec. 19, 1989.

[32] 29 U.S.C. § 2601 et seq.

[33] Pub. L. 100-77, July 22, 1987.

[34] Pub. L. 96-272, April 7, 1986.

abilities Act of 1990[35] and the Anti-Drug Abuse Act Amendments of 1988[36] further demonstrate the federal recognition of social workers as an integral part of the health care system as reflected in congressional policy.

Congressional recognition of social workers provides guidance to the Supreme Court on the federal or nationwide scale as to the importance of the profession in providing mental health services in support of governmental social policy.

E. State Recognition

All U.S. jurisdictions have adopted legislation regulating the practice of social work by providing for licensure or credentialing as a prerequisite to practice.[37] Such action by

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[35] 42 U.S.C. 12101 et seq.

[36] Pub. L. 100-690, Nov. 18, 1988.

[37] Ala. Code § 34-30-1 et seq.; Alaska Stat. § 08.95.010 et seq.; Ariz. Rev. Stat. Ann. § 32-3291 et seq.; Ark. Code Ann. § 17-39-101 et seq.; Cal. Bus. Prof. Code § 4990 et seq.; Colo. Rev. Stat. § 12-43-401 et seq.; Conn. Gen. Stat. Public Act 95-116 (effective Oct. 1, 1995); Del. Code Ann. tit. 24 § 3901 et seq.; D.C. Code Ann. § 2-3308.1 et seq.; Fla. Stat. ch. 491.002 et seq.; Ga. Code Ann. § 43-10A-1 et seq.; Haw. Rev. Stat. § 467D-1 et seq., and 467 E-1 et seq.; Idaho Code § 54-3201 et seq.; Illinois Compiled Stat. Ann. 225 ILCS 20/1 et seq.; Ind. Code § 25-23.6-1-1 et seq.; Iowa Code § 154C.1 et seq.; Kan. Stat. Ann. § 65-6301 et seq.; Ky. Rev. Stat. Ann. § 335.010 et seq.; La. Rev. Stat. Ann. § 37:2701 et seq.; Me. Rev. Stat. Ann. tit. 32 § 7001A et seq.; Md. Code Ann. Health Occup. § 19-101 et seq.; Mass. Gen. L. ch. 112 § 130 et seq.; Mich. Comp. Laws Ann. § 339.1601 et seq.; Minn. Stat. Ann. § 148B.01 et seq.; Miss. Code Ann. § 73-53-1 et seq.; Mo. Rev. Stat. § 337.600 et seq.; Mont. Code Ann. §37-22-101 et seq.; Neb. Rev. Stat. § 71-1, 295 et seq.; Nev. Rev. Stat. § 641B.020 et seq.; N.H. Rev. Stat. Ann.§ 330-A:1 et seq.;N.J. Rev. Stat. § 45:15BB-1 et seq.; N.M. Stat. Ann. §61-31-1 et seq.; N.Y. Educ. Law § 7700 et seq.; N.C. Gen. Stat. § 90B-2 et seq.; N.D. Cent. Code § 43-41-

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state legislatures clearly indicates the recognition of social workers as qualified providers of mental health services. Not only does such recognition elevate the social worker to a professional status, it also provides the foundation on which a privilege must be recognized in order to protect the integrity of social work services.

Local regulation of social work provides consumers with the freedom to choose between qualified mental health care providers. This flexibility is crucial to certain socioeconomic classes of individuals unable to afford social services from psychiatrists or other costly providers. As has been stated, the social worker has been referred to as the "poor man's psychiatrist."[38] This freedom to select a social worker is further enhanced because costs of social work services are reimbursable by insurance companies and other third party programs.[39]

More specifically, Illinois in its Clinical Social Work Practice Act has declared the profession to impact upon the public health, safety and welfare of its citizens and is subject

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[37] (...continued)
01 et seq.; Ohio Rev. Code Ann. §4757.01 et seq.; Okla. Stat. Ann. tit. 59 § 1250 et seq.; Or. Rev. Stat. § 675.510 et seq.;Pa. Cons. Stat. Ann. 63 § 1901 et seq.; R.I. Gen. Laws 5-39.1-2 et seq.; S.C. Code Ann. § 40-63-10 et seq.;S.D. Codified Laws Ann. § 36-26-1 et seq.; Tenn. Code Ann. § 63-23-101 et seq.; Tex. Hum. Res. Code Ann. § 50.001 et seq.; Utah Code Ann. § 58-60-201 et seq.; Vt. Stat. Ann. tit. 61 § 3201 et seq.; Va. Code Ann. § 54.1-3700 et seq.; Wash. Rev. Code § 18.19.010 et seq.; W. Va. Code § 30-30-1 et seq.; Wis. Stat. § 457.01 et seq.; Wyo. Stat. § 33-38-101 et seq.

[38] *Jaffee v. Redmond*, 51 F. 3d 1346, 1357 (7th Cir. 1995) (Citing, *Developments in the Law: Part IV*, 98 Harv. L. Rev. at 1550.).

[39] Gibelman, *What Social Workers Do*, supra note 2, at 9.

to regulation in the public interest.[40] The purpose of the Illinois Clinical Social Work Practice Act is to protect and benefit the public by setting the standards of qualifications, education, training and experience for those who seek to engage in the independent practice of clinical social work and social work and to promote high standards of professional performance.[41]

The professional status of social workers has been recognized by Illinois courts which cited the practice act as indicative of the legislatures concern for the qualifications of the social worker and quality of care rendered. *Horak v. Biris*, 474 N.E.2d at 19. The Illinois practice act also emphasizes the grounds and procedures for disciplinary action including the removal of "incompetent" practitioners from the profession.[42]

Illustrative of the recognition of social work practice on an equal plane with other professions is Illinois legislation, virtually identical to social work, which declares psychology[43] and nursing[44] to impact upon the public health and, thus, like social work, require regulation. Ironically, the medical profession contains no such declaration of public policy in Illinois.[45]

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[40] 225 ILCS 20/1; Similar public policy declarations are found in the state statutes of Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Idaho, Kansas, Kentucky, Louisiana, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, South Dakota, Washington and West Virginia. See supra note 37.

[41] 225 ILCS 20/1.

[42] 225 ILCS 20/19.

[43] 225 ILCS 15/1.

[44] 225 ILCS 65/2.

[45] 225 ILCS 60/1 et seq.

Even without a declaration of public policy indicating the need to protect the public through regulation, the fact that all jurisdictions within the United States, including the District of Columbia and Virgin Islands, have adopted a credentialing procedure for social workers as a prerequisite to practice indicates the professional status attained by social workers. Judicial recognition of the privilege protecting confidential social worker-patient communications should logically follow.

Furthermore, forty-eight (48) jurisdictions (including the District of Columbia and the Virgin Islands) require, in addition to the successful completion of an examination, some level of supervised practice for clinical social workers and other classifications of social workers (i.e., licensed social worker or social work technician) as a prerequisite to licensure.[46] Specifically, Illinois, in addition to requiring a

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[46] Ala. Code § 34-30-29; Alaska Stat. § 08.95.110; Ariz. Rev. Stat. Ann. § 32-3293; Ark. Code Ann. § 17-39-306; Cal. Bus. Prof. Code § 4996.20; Colo. Rev. Stat. § 12-43-403; Conn. Gen. Stat. Chap. 383b § 20-195n; Del. Code Ann. tit. 24 § 3907; D.C. Code Ann. § 2-3308.3, and 2-3308.4; Fla. Stat. ch. 491.005; Ga. Code Ann. § 43-10A-12; Idaho Code § 54-3207; Illinois Compiled Stat. Ann. 225 ILCS 20/9; Ind. Code § 25-23.6-5-2; Kan. Stat. Ann. § 65-6306; Ky. Rev. Stat. Ann. § 335.100; La. Rev. Stat. Ann. § 37:2706; Me. Rev. Stat. Ann. tit. 32 § 7053; Md. Code Ann. Health Occup. § 19-302; Mass. Gen. L. ch. 112 § 131; Mich. Comp. Laws Ann. § 339.1604; Minn. Stat. Ann. § 148B.21; Miss. Code Ann. § 73-53-13; Mo. Rev. Stat. § 337.615; Mont. Code Ann. §37-22-301; Neb. Rev. Stat. § 71-1, 314; Nev. Rev. Stat. § 641B.230 and 641B.240; N.H. Rev. Stat. Ann.§ 330-A:16-d; N.J. Rev. Stat. § 45:15BB-6; N.M. Stat. Ann. §61-31-9; N.C. Gen. Stat. § 90B-7; N.D. Cent. Code § 43-41-05; Ohio Rev. Code Ann. §4757.09; Okla. Stat. Ann. Tit. 59 § 1261.1; Or. Rev. Stat. § 675.530; R.I. Gen. Laws 5-39.1-8; S.C. Code Ann. § 40-63-70; S.D. Codified Laws Ann. § 36-26-17; Tenn. Code Ann. § 63-23-104; Tex. Hum. Res. Code Ann. § 50.024; Utah Code Ann. § 58-60-205; Vt. Stat. Ann. tit. 61 § 3205; Va. Code Ann. § 54.1-2400; Wash. Rev. Code
(continued...)

doctorate degree in social work mandates 2000 hours of face to face or group supervision for an individual seeking licensure as a clinical social worker;[47] a masters degree in social work and 3000 hours of supervision for an individual seeking licensure as a clinical social worker,[48] and a bachelors degree from an accredited school and three (3) years of supervision for an individual seeking licensure as a social worker.[49] This legislative recognition of the need for supervision prior to licensure emphasizes the professional status attained by social workers.

Thirty-eight (38) states mandate continuing education as a prerequisite to licensure renewal.[50] Mandatory continuing education demonstrates the emphasis placed by the legisla-

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[46] (...continued)
§ 18.19.110; W. Va. Code § 30-30-5; Wis. Stat. Ann. § 457.08; Wyo. Stat. § 33-38-106.

[47] 225 ILCS 20/9(3)(b).

[48] 225 ILCS 20/9(3)(a).

[49] 225 ILCS 20/9A.

[50] E.g. Ala. Code § 34-30-26; Alaska Stat. § 08.95.040; Ariz. Rev. Stat. Ann. § 32-3273; Ark. Code Ann. § 17-39-203; Del. Code Ann. tit. 24 § 3912; D.C. Code Ann. § 2-3305.10; Fla. Stat. ch. 491.007; Ga. Code Ann. § 43-10A-16; Illinois Compiled Stat. Ann. 225 ILCS 20/11; Iowa Code § 154C.4; Kan. Stat. Ann. § 65-6313; La. Rev. Stat. Ann. § 37:2710; Me. Rev. Stat. Ann. tit. 32 § 7060; Md. Code Ann. Health Occup. § 19-308; Mass. Gen. L. ch. 112 § 136; Minn. Stat. Ann. § 148B.22; Miss. Reg. Chp. 11 § 11-13; Mo. Rev. Stat. § 337.627; Mont. Code Ann. §37-22-304; Neb. Rev. Stat. § 71-1, 315; Nev. Rev. Stat. § 641B.280, 641B.240; N.H. Rev. Stat. Ann.§ 330-A:8; N.M. Stat. Ann. §61-31-14; N.C. Gen. Stat. § 90B-9; N.D. Cent. Code § 43-41-12; Ohio Rev. Code Ann. §4757.11; Okla. Stat. 59 § 1261.1; Or. Rev. Stat. § 675.560; R.I. Gen. Laws 5-39.1-7; S.C. Code Ann. § 40-63-80; S.D. Codified Laws Ann. § 36-26-26; Tenn. Code Ann. § 63-23-103; Tex. Hum. Res. Code Ann. § 50.034; W. Va. Code § 30-30-10; Wyo. Stat. § 33-38-107.

ture upon the importance of social workers maintaining current professional standards relative to the practice.

While technically in existence for many years, the recognition of social work as a profession represents a relatively recent phenomenon. All states presently require credentialing prior to practicing as a social worker, but thirty (30) states have adopted practice acts relative to credentialing since 1979.[51] While social work may not have been the beneficiary of analysis through previous judicial decisions relative to privilege and/or privacy issues, the status placed upon the profession by state legislatures through the practice acts places social work communications within the parameters of Rule 501.

Based upon the definition of the practice, the growth of the profession, the recognition by state legislatures for the need of regulation along with the flexibility placed in the judiciary by Congress in adopting Rule 501, communications between social workers and patients should be recognized as privileged under Rule 501.

F. A Vast Majority of States Recognize a Statutory Privilege for Confidential Communications Between a Clinical Social Worker and Patient

The fact that all states have statutorily recognized some form of the psychotherapist-patient privilege of confidential

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[51] 1980 Tennessee; 1981 Florida; Texas; 1983 Montana; New Hampshire; North Carolina; North Dakota; Virgin Islands; 1984 Georgia; Iowa; Ohio; West Virginia; 1985 Connecticut; 1986 District of Columbia; Nebraska; Vermont; Wyoming; 1987 Minnesota; Mississippi; Nevada; Pennsylvania; Washington; 1988 Alaska; Arizona; 1989 Hawaii; Missouri; New Mexico; 1990 Indiana; 1991 New Jersey; 1992 Wisconsin; see *supra* note 37.

communications[52] is further indicative of the state recognition of the profession and the importance of confidential communications between a social worker and patient. Currently, forty-five (45) states have included social workers within such protections.[53] Such legislative recognition provides this Court with guidance from the states in its analysis of the application of Rule 501. As appropriately stated by the Seventh Circuit, "This widespread recognition of the psychotherapist-patient privilege in all fifty states is strong evidence that 'experience with [the privilege] has been favorable.' " *Jaffee v. Redmond*, 51 F. 3d 1346, 1357 (7th Cir. 1995).

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[52] *Developments in the Law Part IV*, 98 Harv. L. Rev. at 1539 (noting 45 states enacted statutes as of 1985) since then see; Alaska Stat. §08.86.200 (1994); Iowa Code §622.10 (1993); Neb. Rev. Stat. §27-504 (1994); S.C. Code Ann. §44-22-90 (Law. Co-op 1993); W. Va. Code §27-3-1 (1994).

[53] Ariz. Rev. Stat. Ann. §32-32-83; Ark. Code Ann. §17-39-107; Cal. Evid. Code §1012; Colo. Rev. Stat. §13-90-107; Conn. Gen. Stat. Ann. 552-146q; Del. Code Ann. tit. 24, §3913; D.C. Code Ann. §14-307; Fla. Stat. ch. §90-503; Ga. Code Ann. §24-9-21; Idaho Code §54.3213; Illinois Compiled Stat. Ann. 225 ILCS 20/16, 740 ILCS 110/10; Ind. Code Ann. §25-23.6-6-1; Iowa Code Ann. §622.10; Kan. Stat. Ann. §65-6315; Ky. R. Evid., Rule 507; La. Code Evid. Art. 510; Me. Rev. Stat. Ann. tit. §7005; Md. Code Ann., Cts. & Jud. Proc. §9-121; Mass. Gen. Laws C-112 §135B; Mich. Comp. Laws Ann. §339.1610; Minn. Stat. Ann. §595.02(g); Miss. Code Ann. 73-30-17 §73-53-29; Mo. Rev. Stat. 337.540, §337.636; Mont. Code Ann. §37-22-401; Neb. Rev. Stat. §71-1,335; Nev. Rev. Stat. Ann. §49.215-254; N.H. Rev. Stat. Ann. §330-A:19; N.J. Stat. Ann. §45:15BB-13; N.M. Stat. Ann. §61-31-24; N.Y. Civ. Prac. L. & R. §4508; N.C. Gen. Stat. §8-53.7; Ohio Rev. Code Ann. §2317.02(G); Okla. Stat. Ann. tit. 59 §1261; Or. Rev. Stat. §40.250, Rule 504-4; R.I. Gen. Laws 5-39-1-4; S.C. Code Ann. 44-22-90; S.D. Codified Laws Ann. §36-26-30; Tenn. Code Ann. §63-23-107; Tex. R. Civ. Evid. Rule 510; Utah Code Ann. §58-60-144, Utah R. Evid. 506; Vt. R. Evid. 503; Va. Code Ann. §8.01-400.2; Wash. Rev. Code §18.19-180; W. Va. Code §30-30-12; Wis. Stat. Ann. §905.04; Wyo. Stat. §33-38-109.

In analyzing the application of Rule 501 to the current circumstances, the Supreme Court may take note of the relevant state privilege laws in determining whether to retain, or recognize, them in the federal system. *United States v. Gillock*, 445 U.S. 360, 369 n.8, 100 S.Ct. 1185, 63 L.Ed. 2d 455 (1980). An overwhelming endorsement through the enactment by all jurisdictions of privilege laws provides the necessary backdrop for federal recognition of the privilege. Based upon the wisdom of the state legislatures, and the strong policy of comity between state and federal sovereignties, *William T. Thompson Co. v. General Nutrition Corp.*, 671 F.2d 100, 104 (3d Cir. 1982), recognition of the privilege is mandated in light of reason and experience.

V. EFFECTIVE PSYCHOTHERAPY IS BASED UPON A FOUNDATION OF TRUST AND CONFIDENCE AND CONCESSIONS TO SUCH CONFIDENTIALITY WOULD UNDERMINE THERAPEUTIC EFFECTIVENESS

A. Psychotherapy is Based Upon Trust and Confidence

The relationship between a psychotherapist and patient is based upon trust obtained through confidential communications. The very essence of psychotherapy is confidential, personal revelations of matters about which the patient is normally reluctant to reveal or discuss.[54] Generally, psychotherapy analysis involves a process which explores the most hidden aspects of personality, disclosing matters theretofore

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[54] Guttmacher, M. & H. Weinhofen, *Psychiatry and the Law 269-87* (1952); Slovenko, Ralph, *Psychotherapy, Confidentiality, and Privileged Communication 37-50* (1966); Group for the Advancement of Psychiatry, Rep. No. 45, at 92 (1960); Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 Wayne L. Rev. 609 (1964).

unknown, perhaps, even to the conscious mind of the patient. In order to express such innermost thoughts, the patient must feel the utmost honesty and trustworthiness of the psychotherapist. As has been stated, the etymology of the word "person" is illustrative of the description of psychotherapeutic revelations:

> The word stems from the Latin "persona," meaning the character of a novel or play. Persona is the public personality, those aspects which one displays to the world as contrasted with the private personality which exists behind the social facade. It is the mask which is worn by an individual in response to the demands of social convention and tradition. The mask is what we daily see; it conceals the inner nature and conflicts of the individual. Hopefully, in psychotherapy, the mask is removed.[55]

Psychotherapists encourage patients to reveal thoughts without regard to the usual social amenities. It is without question that patients lower their defenses and reveal personal inner thoughts with the expectation of strict confidence. Such confidentiality is necessary for meaningful communication, proper diagnosis and effective therapeutic treatment.[56] Because of the unique character of psychother-

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[55] Slovenko, *Psychotherapy, Confidentiality, and Privileged Communication 40* (1966).

[56] *See e.g.*, Proposed Rules of Evidence for United States Courts and Magistrates, 56 F.R.D. 183, 242 (1972) (proposed rule 504 advisory committee note) ("there is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment") (quoting Report No. 45, Group for the Advancement of Psychiatry 92 (1960); Baytion, Catherine M., Note & Comment, Toward Uniform Application of a Federal Psychotherapist-Patient Privilege, 70 Wash. L. Rev. 153, 157 (1995) ("successful treatment of mental and emotional conditions depends upon confidentiality because treatment often requires patients to reveal socially unacceptable

(continued...)

apy, a psychotherapist cannot successfully treat a patient unless he or she can assure the patient of complete confidentiality.

Evidence relative to psychotherapy sessions must be maintained in confidence and not revealed to those outside the professional relationship, including in judicial proceedings (with various exceptions), for even a single concession to secrecy would undermine the whole purpose of therapy which is to build a trusting relationship.[57] As has been stated, "patient-centered psychotherapy" develops a:

> Contractual agreement between the therapist and the patient to engage in a two-person enterprise. This arrangement provides the essential condition for a unique emotional experience. As a result of what the patient is enabled to learn about himself under this special circumstance, he may be able to alter his behavior. The ultimate decision to change . . . however, rests with him and not with the therapist. Since confi-

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[56] (...continued)
thoughts and feelings") (citing Sidney Jourard, Some Psychological Aspects of Privacy, 31 Law & Contemp. Probs. 307, 311 (1966); Keith Levick, Privilege Communication: Does it Really Exist?, 62 Soc. Casework, No. 4, at 235, 236 (April, 1981) (therapists "need to protect the delicate relationship between themselves and their clients in order to maintain the full trust and confidence necessary for successful therapeutic relationships"; "[p]sychotherapy, by its very nature[,] is worthless unless the patient feels assured from the onset that whatever he may say will be forever kept confidential) (quoting Judge Luther Alverson, Atlanta Supreme Court, Address to the North Georgia Chapter of the national Association of Social Workers, Atlanta, Georgia (October 21, 1958)).

[57] Dubbelday, Catharina J.H., *Comment, The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved,* 34 Emory L.J. 777, 795-800 (1985).

> dentiality is a sine qua non of patient-oriented therapy, its very existence depends on the protection of privileged communication.[58]

Thus, confidentiality and the recognition of a privilege between the social worker and patient is a technical necessity for effective therapy or counseling to ensue.

Commentators have observed that the patient must be able to discuss his fears and anxieties with the psychotherapist without concern that his innermost thoughts, feelings and troubles will not be disclosed to the public at large.[59] Successful treatment rests upon assurances of complete confidentiality.[60] Thus, the psychotherapist-patient privilege should be recognized in light of reason and experience.

The judiciary has also observed the essential character of confidential communications between a psychotherapist and patient. As stated:

> Where there may be exceptions to this general rule . . . , there is wide agreement that confidentiality is a sine qua non for successful psychiatric treatment. The relationship may well be likened to that of the priest-penitent or the lawyer-client. Psychiatrists not only explore the very depths of their patients' conscious, but their unconscious feelings and attitudes as well. Thera-

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[58] Dubey, Joseph, M.D., *Confidentiality as a Requirement of the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy*. Am. J. Psychiatry 131 (10 October 1974).

[59] Dubbelday, Catharine J.H., *Comment, The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved,* 34 Emory L.J. 777, 799 (1985) (Quoting A. Anastasi, *Fields of Applied Psychology* 346-47 (1979)).

[60] Soffin, Ellen S., *Note, The Case for a Federal Psychotherapist-Patient Privilege That Protects Patient Identity*, 1985 Duke L.J. 1217, 1221.

> peutic effectiveness necessitates going beyond a patient's awareness and, in order to do this, it must be possible to communicate freely. A threat to secrecy blocks successful treatment.

In re Zuniga, 714 F.2d 632, 637 (6th Cir. 1983).

B. Exceptions Do Not Eviscerate the Need for a Privilege

All privileges require exceptions under certain circumstances. *In the Matter of DDS*, 869 P.2d 160, 163, n. 4 (Alaska 1994). The existence of exceptions does not eliminate the need to recognize a privilege in the first place. Petitioner argues that the existence of exceptions under state laws somehow transforms the confidential relationship into one not in need of protection. However, Petitioner's basis for arriving at this conclusion is predicated upon references to cases with no similarities to the current circumstances. Matters involving criminal charges, child abuse and the like may be viable exceptions to a recognized privilege. However, this does not overcome the need for an initial recognition of the privilege.

VI. CONCLUSION

AASSWB, for the reasons stated herein, respectfully requests this Honorable Court affirm the decision of the Seventh Circuit Court of Appeals recognizing a privilege protecting confidential communications between a clinical social worker and patient under Rule 501.

Respectfully submitted,

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